FROM THE EDITOR – Dr Jackie Jones RN PhD

'SOUL FOOD' IN AND OF NURSING – WHAT IS IT?

Having just enjoyed the debates at the International Academy of Nursing Editors (INANE) meeting where many of the delegates were from North America, I find myself writing this Editorial amidst fears of a major terrorist plot to blow up aircraft leaving Heathrow, London for the United States of America. Such terrorists are said to be selling their soul for their 'spiritual' cause. Nurses on the other hand make it their cause to help people in times of spiritual distress. As one of our papers in this edition suggests (Day) interventions by health professionals, such as cardiac rehabilitation, are said to promote spiritual recovery, but what constitutes recovery of the spirit and how does one therefore feed the soul? Not all individuals relate spirituality to religion nor do they consider themselves very spiritual. However, spiritual 'awakening' is said to occur particularly in the face of adversity, illness, disease and mental illness. Many nurses may, on reading this, question what this has to do with 'real' practice. Others will nod because they have been 'awakened' spiritually through their practice as nurses and encounters with patients. Yet others will consider themselves very spiritual in general or through formalised religious beliefs.

Even the most cursory glance at the literature reveals spirituality as a growth area of nursing research. Key issues arising from this body of work include a lack of clarity in terminology, language and definitions and a clash with the personal values and comfort level of nurses themselves. This clash of values and comfort level of nurses around spirituality can be problematic.

For example, in a recent research paper Wilding et al (2006) describe some of the perceived boundaries between mental illness and spirituality and the consequences of negative stereotypes and prejudice by health professionals as experienced by mental health patients. Hearing voices could be consistent with a psychotic episode or consistent with acknowledging one's own spiritual guidance. Is this spiritual element of being human still taboo and hidden in a similar manner to that of being named a healer (nurse) in one century or a witch in another dependent on the politics and prevailing discourses of the time? Participants in the Wilding study described a uniquely experienced journey of spiritual beliefs where 'profound changes can occur particularly following profound experiences' (Wilding et al 2006, p.151). This journey was considered to be life-sustaining and therefore vital to the participants' ongoing wellbeing.

Returning again to the notion of relevance to practice it is important to highlight that the Australian Nursing and Midwifery Council states that a registered nurse 'facilitates a physical, psychosocial, cultural and spiritual environment that promotes individual/group safety and security' (ANMC 2006). Wilding et al advocate health professionals 'take a wide and inclusive view of what spirituality can be (2006, p.150)'; reminding us that these views do not remain static and therefore the 'food for the soul' that is needed at a particular time also varies. Being self reflective of ones own spiritual beliefs and the relationships between spirituality and client care is increasingly important. Whether nurses have yet realised its importance against a backdrop of relentless technological growth and change, our prevailing discourses, remain to be seen.

Listening carefully to clients and moving away from a 'one size fits all' approach to care dimensions will be needed if nurses are to hear what a person values about their life and the care they believe they need in their encounters with the system. Nurses need also to recognise that some aspects of a patient's value system may mean patients are afraid to share their values with those caring for them. Nurses are constantly being challenged by the needs and beliefs of those around them; they also challenge and are being challenged by their own beliefs and values.

Contemporary health care and existing dominant discourses of the body and soul are being challenged by the rigors of science such as described by quantum physics, vibrational medicine (O'Brien 2002, p.164), energetic healing and various bodywork modalities. There is a timeliness therefore about the need to consider flexibility in service provision, recognise and attend to some current rigidity of practice and thinking with, in and between culturally diverse boundaries and parameters as offered by the likes of Wilding et al. In this edition of AJAN, papers explore a variety of boundaries, systems and beliefs related to the practice and service delivery of nurses.

In our first paper Gardner et al outline research conducted to inform the development of standards for nurse practitioner education in Australia and New Zealand. Findings from this research include support for master's level education as preparation for the nurse practitioner and for programs with a strong clinical learning component, in-depth education for the sciences of specialty practice and centrality of student directed and flexible learning models. Next, Cioffi using a qualitative descriptive study provides a snapshot of the experiences of culturally diverse family members who make the decision to stay with their relatives in acute medical and surgical wards. Three main roles identified were: carrying out in-hospital roles; adhering to ward rules; and facing concerns. Findings indicate nurses and family members could benefit from negotiating active partnerships, and

that family friendly ward environments need to be fostered supported by appropriate policies.

Day and Batten having identified that cardiac rehabilitation programs have been based on research with almost exclusively male participants investigate women's perceptions of the contribution of cardiac rehabilitation to their recovery from a myocardial infarction. Using Glaserian grounded theory the core theme that emerged from their data was 'regaining everydayness'. These authors found programs did not meet the needs of all participants and it was apparent that one size does not fit all. The final research paper from Brumley et al aimed to improve access to clinical information for nurses and doctors providing after hours community palliative care in a regional Australian setting. They describe an action research project designed to improve collation and distribution of succinct, pertinent and timely information about unstable palliative care patients, to nurses and general practitioners (GPs) involved in after hours care.

Dewar reviews the nursing research literature on chronic pain in the older person living in the community. She argues that to provide care, the many parameters of chronic pain, which include physical as well as the psycho-social impact and the effect of pain on patients and their families, must be carefully assessed. Further, that the beliefs of the older person about pain and pain management are also important and not necessarily sought. Our final scholarly paper by Clark et al draws on experiences from a national clinical research study to highlight the registration issues for nurses who wish to practice nationally, particularly those practicing within the telehealth sector. The authors found that the state and territory structure of the regulation of nursing in Australia is a barrier to the changing and evolving role of nurses in the 21st century and consider this a significant factor when considering workforce planning.

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